Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential in accordance with HIPAA.

Patient Name _____ **Birth date** _____ **Chart #** _____
First MI Last

SSN _____ **Male Female Home Phone** _____ **Cell Phone** _____

Address _____**Apt #** _____ **City** _____ **State** _____ **Zip** _____

Email address: _____

Circle appropriate status: Minor Single Married Separated Divorced Widowed

Patient's or Parent's Employer _____ **Work Phone** _____ **Ext:** ____

Business Address _____**City** _____**State** _____ **Zip** _____

Spouse's Name _____ **Employer** _____**Work Phone** _____

Spouse's SSN _____ **Spouse's Date of Birth** _____

If patient is a student, name of school/college _____

Whom may we thank for referring you? _____

If not a physician circle how you got our name: Yellow pages Internet Insurance Plan Friend/Family

Person to contact in case of an emergency _____ **Phone Number** _____

Responsible Party

Name of person responsible for this account _____ **Relationship to Patient** _____

Address if different from above _____ **Home Phone** _____

Driver's License# _____ **Birth date** _____**Social Security #** __ _____

Employer _____ **Work Phone** _____ **Ext** _____

Primary Insurance Information-Provide copy of current card

Name of Insured _____ **Relationship to Patient: Self Spouse Parent Other**

Birth date _____ **Social Security #** _____ **Effective date of Insurance** _____

Name of Employer _____**Work Phone** _____

Address of Employer _____ **City** _____**State** ____ **Zip** _____

Insurance Company _____ **Subscriber #** _____ **Group#** _____

Insurance Co. Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Phone# _____ **Deductible** _____ **Co-pay** _____

Please complete the other side of this form

Secondary Insurance Information-Provide copy of current card

Name of Insured _____ Relationship to Patient: Self Spouse Parent Other

Birth Date _____ Social Security # _____ Effective date of Insurance _____

Name of Employer _____Work Phone _____

Address of Employer _____ City _____State ____ Zip _____

Insurance Company _____ Subscriber # _____ Group# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Insurance Phone # _____ Deductible _____ Co-pay _____

If you have any other coverage please advise the front desk.

Authorization and Release

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of Patient (or parent if minor) Date

Authorization of Treatment

I hereby authorize that _____has/have my permission to give authorization of treatment for the above named patient. The relationship(s) of this/these person(s) to the patient is _____.

_____ _____

Signature of Parent or Legal Guardian Date

Agreement to Pay for Non-Covered Services

I understand and agree that if my insurance is not in effect on the date of services rendered or if the insurance company determines that I am responsible for charges for which I have not previously rendered payment that I will pay in full for these services within 30 days of receiving a bill from James B. Maddox, M.D., P.A.

_____ _____

Signature of Patient or Responsible Party Date